THE MANHATTAN LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, B, C, D, F, G, M AND N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. The Manhattan Life Insurance Company offers six of the fourteen plans available.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*	Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

***Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

The Manhattan Life Insurance Company
Annual Preferred Premium Rates
FOR USE IN INDIANA ZIP CODES
462-464

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
65	1,160	1,409	1,620	1,477	1,682	1,486	1,330	1,174	1,333	1,618	1,861	1,697	1,932	1,706	1,528	1,349
66	1,160	1,409	1,620	1,477	1,682	1,486	1,330	1,174	1,333	1,618	1,861	1,697	1,932	1,706	1,528	1,349
67	1,160	1,409	1,620	1,477	1,682	1,486	1,330	1,174	1,333	1,618	1,861	1,697	1,932	1,706	1,528	1,349
68	1,207	1,464	1,685	1,536	1,749	1,545	1,383	1,221	1,387	1,683	1,935	1,765	2,010	1,775	1,589	1,403
69	1,254	1,523	1,752	1,597	1,818	1,606	1,438	1,270	1,442	1,750	2,013	1,835	2,089	1,846	1,652	1,458
70	1,305	1,585	1,823	1,661	1,892	1,671	1,496	1,320	1,500	1,821	2,095	1,909	2,174	1,920	1,719	1,517
71	1,358	1,648	1,895	1,729	1,967	1,738	1,556	1,374	1,560	1,894	2,178	1,986	2,261	1,997	1,788	1,579
72	1,410	1,712	1,969	1,796	2,044	1,805	1,617	1,428	1,620	1,967	2,263	2,063	2,349	2,074	1,857	1,640
73	1,466	1,779	2,046	1,866	2,124	1,876	1,680	1,483	1,684	2,044	2,351	2,144	2,440	2,156	1,930	1,704
74	1,514	1,838	2,115	1,928	2,195	1,939	1,736	1,532	1,739	2,112	2,430	2,215	2,522	2,227	1,994	1,761
75	1,561	1,895	2,181	1,988	2,263	1,999	1,790	1,580	1,794	2,178	2,505	2,283	2,601	2,296	2,057	1,815
76	1,607	1,952	2,244	2,046	2,329	2,058	1,842	1,626	1,847	2,242	2,578	2,351	2,676	2,364	2,117	1,868
77	1,648	2,001	2,302	2,099	2,390	2,111	1,890	1,669	1,894	2,300	2,644	2,412	2,746	2,425	2,171	1,916
78	1,690	2,051	2,359	2,151	2,449	2,163	1,936	1,710	1,941	2,356	2,710	2,471	2,813	2,485	2,225	1,965
79	1,729	2,098	2,413	2,200	2,505	2,213	1,981	1,749	1,986	2,411	2,772	2,528	2,878	2,542	2,276	2,010
80	1,764	2,142	2,463	2,246	2,556	2,259	2,023	1,785	2,027	2,460	2,830	2,579	2,937	2,595	2,323	2,051
81	1,797	2,182	2,510	2,288	2,605	2,301	2,060	1,820	2,065	2,508	2,884	2,629	2,994	2,643	2,367	2,090
82	1,829	2,221	2,554	2,328	2,650	2,341	2,097	1,854	2,102	2,551	2,933	2,675	3,046	2,690	2,408	2,130
83	1,857	2,255	2,594	2,365	2,693	2,378	2,130	1,886	2,135	2,591	2,980	2,716	3,093	2,732	2,446	2,166
84	1,886	2,289	2,633	2,400	2,733	2,413	2,162	1,919	2,166	2,630	3,024	2,758	3,140	2,773	2,484	2,205
85	1,910	2,320	2,668	2,432	2,769	2,446	2,190	1,952	2,195	2,664	3,064	2,794	3,181	2,810	2,516	2,242
86	1,934	2,347	2,700	2,461	2,803	2,476	2,218	1,984	2,222	2,696	3,101	2,828	3,219	2,844	2,549	2,280
87	1,955	2,374	2,731	2,492	2,834	2,505	2,248	2,018	2,247	2,728	3,138	2,863	3,257	2,879	2,583	2,318
88	1,978	2,400	2,760	2,520	2,865	2,535	2,277	2,050	2,272	2,758	3,172	2,897	3,292	2,912	2,616	2,355
89	1,993	2,421	2,791	2,551	2,897	2,565	2,307	2,084	2,290	2,782	3,206	2,931	3,329	2,948	2,650	2,394
90	2,008	2,444	2,823	2,583	2,930	2,597	2,338	2,119	2,308	2,807	3,243	2,968	3,365	2,983	2,686	2,434
91	2,021	2,465	2,854	2,614	2,962	2,628	2,368	2,155	2,322	2,833	3,279	3,003	3,403	3,020	2,721	2,476
92	2,033	2,487	2,886	2,647	2,996	2,661	2,401	2,191	2,336	2,858	3,316	3,041	3,442	3,057	2,759	2,517
93	2,045	2,510	2,919	2,679	3,030	2,694	2,433	2,228	2,349	2,884	3,354	3,077	3,481	3,095	2,795	2,559
94	2,057	2,533	2,954	2,713	3,066	2,728	2,467	2,267	2,364	2,911	3,394	3,118	3,522	3,134	2,836	2,604
95	2,069	2,557	2,989	2,748	3,102	2,762	2,503	2,306	2,377	2,937	3,434	3,158	3,564	3,174	2,874	2,650
96	2,080	2,581	3,024	2,784	3,139	2,799	2,538	2,347	2,391	2,964	3,475	3,198	3,606	3,216	2,916	2,696
97	2,092	2,603	3,061	2,819	3,177	2,834	2,574	2,388	2,404	2,991	3,516	3,239	3,650	3,257	2,957	2,744
98	2,104	2,628	3,098	2,857	3,214	2,872	2,611	2,431	2,418	3,020	3,559	3,282	3,693	3,299	3,001	2,793
99	2,116	2,653	3,136	2,895	3,254	2,910	2,650	2,474	2,431	3,048	3,604	3,326	3,739	3,343	3,046	2,844

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.

The Manhattan Life Insurance Company
Annual Standard Premium Rates
FOR USE IN INDIANA ZIP CODES
462-464

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
65	1,276	1,549	1,782	1,625	1,850	1,634	1,463	1,292	1,467	1,779	2,047	1,867	2,125	1,877	1,682	1,483
66	1,276	1,549	1,782	1,625	1,850	1,634	1,463	1,292	1,467	1,779	2,047	1,867	2,125	1,877	1,682	1,483
67	1,276	1,549	1,782	1,625	1,850	1,634	1,463	1,292	1,467	1,779	2,047	1,867	2,125	1,877	1,682	1,483
68	1,328	1,611	1,854	1,690	1,923	1,699	1,521	1,344	1,526	1,851	2,129	1,942	2,210	1,952	1,749	1,543
69	1,379	1,676	1,928	1,756	2,000	1,766	1,582	1,397	1,586	1,925	2,215	2,019	2,297	2,030	1,817	1,605
70	1,436	1,743	2,006	1,828	2,080	1,838	1,646	1,453	1,650	2,002	2,305	2,100	2,391	2,112	1,892	1,670
71	1,494	1,814	2,085	1,902	2,164	1,912	1,712	1,510	1,716	2,084	2,397	2,184	2,487	2,196	1,967	1,737
72	1,552	1,883	2,166	1,975	2,248	1,986	1,778	1,571	1,782	2,164	2,490	2,269	2,584	2,282	2,043	1,804
73	1,612	1,958	2,250	2,052	2,336	2,064	1,848	1,632	1,853	2,248	2,585	2,359	2,685	2,372	2,124	1,874
74	1,665	2,023	2,326	2,120	2,414	2,132	1,909	1,685	1,913	2,323	2,673	2,437	2,774	2,450	2,194	1,936
75	1,717	2,085	2,399	2,188	2,490	2,198	1,969	1,738	1,973	2,397	2,755	2,512	2,860	2,526	2,262	1,997
76	1,768	2,146	2,469	2,250	2,562	2,263	2,026	1,789	2,032	2,466	2,837	2,585	2,944	2,600	2,328	2,054
77	1,814	2,202	2,532	2,309	2,629	2,322	2,079	1,835	2,084	2,530	2,909	2,653	3,021	2,668	2,388	2,107
78	1,859	2,256	2,595	2,366	2,694	2,379	2,130	1,881	2,136	2,592	2,982	2,718	3,094	2,734	2,449	2,162
79	1,902	2,308	2,655	2,419	2,755	2,434	2,179	1,923	2,184	2,651	3,049	2,780	3,166	2,795	2,504	2,210
80	1,941	2,356	2,709	2,470	2,812	2,484	2,224	1,964	2,230	2,707	3,113	2,838	3,231	2,854	2,556	2,256
81	1,977	2,400	2,761	2,517	2,866	2,531	2,267	2,001	2,272	2,759	3,172	2,892	3,293	2,908	2,604	2,299
82	2,012	2,443	2,808	2,561	2,916	2,575	2,307	2,039	2,312	2,806	3,227	2,943	3,350	2,959	2,649	2,343
83	2,043	2,480	2,853	2,601	2,962	2,616	2,343	2,074	2,348	2,851	3,278	2,988	3,402	3,005	2,690	2,384
84	2,074	2,518	2,896	2,640	3,007	2,655	2,378	2,111	2,384	2,893	3,326	3,034	3,454	3,050	2,733	2,426
85	2,102	2,552	2,935	2,675	3,047	2,690	2,410	2,146	2,414	2,931	3,371	3,074	3,500	3,090	2,767	2,466
86	2,128	2,582	2,970	2,708	3,083	2,723	2,440	2,182	2,444	2,967	3,411	3,112	3,541	3,128	2,804	2,508
87	2,151	2,611	3,003	2,741	3,118	2,755	2,473	2,220	2,471	3,001	3,452	3,149	3,582	3,167	2,841	2,549
88	2,176	2,640	3,036	2,773	3,152	2,788	2,505	2,255	2,499	3,034	3,489	3,187	3,621	3,204	2,878	2,591
89	2,192	2,663	3,070	2,806	3,187	2,821	2,538	2,293	2,519	3,061	3,527	3,224	3,662	3,243	2,916	2,634
90	2,209	2,688	3,105	2,841	3,223	2,857	2,571	2,332	2,539	3,088	3,567	3,265	3,702	3,282	2,955	2,677
91	2,223	2,712	3,140	2,876	3,258	2,891	2,605	2,371	2,555	3,116	3,607	3,304	3,743	3,322	2,994	2,723
92	2,236	2,736	3,175	2,911	3,296	2,928	2,642	2,411	2,570	3,144	3,647	3,345	3,787	3,363	3,035	2,768
93	2,249	2,761	3,211	2,946	3,334	2,963	2,676	2,451	2,584	3,172	3,689	3,385	3,829	3,404	3,075	2,815
94	2,262	2,787	3,249	2,984	3,372	3,001	2,714	2,493	2,600	3,203	3,734	3,429	3,875	3,448	3,119	2,865
95	2,275	2,813	3,287	3,023	3,413	3,039	2,753	2,536	2,614	3,231	3,777	3,474	3,920	3,492	3,162	2,916
96	2,288	2,839	3,326	3,062	3,453	3,079	2,792	2,582	2,630	3,260	3,823	3,518	3,967	3,538	3,207	2,967
97	2,301	2,864	3,367	3,101	3,494	3,118	2,831	2,627	2,644	3,291	3,868	3,564	4,014	3,582	3,253	3,018
98	2,314	2,891	3,408	3,142	3,535	3,159	2,872	2,674	2,660	3,322	3,915	3,610	4,063	3,630	3,300	3,073
99	2,327	2,918	3,450	3,184	3,580	3,201	2,916	2,722	2,674	3,352	3,964	3,659	4,113	3,677	3,350	3,128

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.

The Manhattan Life Insurance Company
Annual Preferred Premium Rates
FOR USE IN INDIANA ZIP CODES ALL EXCEPT
462-464

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
65	983	1,194	1,373	1,252	1,425	1,259	1,127	995	1,130	1,371	1,577	1,438	1,637	1,446	1,295	1,143
66	983	1,194	1,373	1,252	1,425	1,259	1,127	995	1,130	1,371	1,577	1,438	1,637	1,446	1,295	1,143
67	983	1,194	1,373	1,252	1,425	1,259	1,127	995	1,130	1,371	1,577	1,438	1,637	1,446	1,295	1,143
68	1,023	1,241	1,428	1,302	1,482	1,309	1,172	1,035	1,175	1,426	1,640	1,496	1,703	1,504	1,347	1,189
69	1,063	1,291	1,485	1,353	1,541	1,361	1,219	1,076	1,222	1,483	1,706	1,555	1,770	1,564	1,400	1,236
70	1,106	1,343	1,545	1,408	1,603	1,416	1,268	1,119	1,271	1,543	1,775	1,618	1,842	1,627	1,457	1,286
71	1,151	1,397	1,606	1,465	1,667	1,473	1,319	1,164	1,322	1,605	1,846	1,683	1,916	1,692	1,515	1,338
72	1,195	1,451	1,669	1,522	1,732	1,530	1,370	1,210	1,373	1,667	1,918	1,748	1,991	1,758	1,574	1,390
73	1,242	1,508	1,734	1,581	1,800	1,590	1,424	1,257	1,427	1,732	1,992	1,817	2,068	1,827	1,636	1,444
74	1,283	1,558	1,792	1,634	1,860	1,643	1,471	1,298	1,474	1,790	2,059	1,877	2,137	1,887	1,690	1,492
75	1,323	1,606	1,848	1,685	1,918	1,694	1,517	1,339	1,520	1,846	2,123	1,935	2,204	1,946	1,743	1,538
76	1,362	1,654	1,902	1,734	1,974	1,744	1,561	1,378	1,565	1,900	2,185	1,992	2,268	2,003	1,794	1,583
77	1,397	1,696	1,951	1,779	2,025	1,789	1,602	1,414	1,605	1,949	2,241	2,044	2,327	2,055	1,840	1,624
78	1,432	1,738	1,999	1,823	2,075	1,833	1,641	1,449	1,645	1,997	2,297	2,094	2,384	2,106	1,886	1,665
79	1,465	1,778	2,045	1,864	2,123	1,875	1,679	1,482	1,683	2,043	2,349	2,142	2,439	2,154	1,929	1,703
80	1,495	1,815	2,087	1,903	2,166	1,914	1,714	1,513	1,718	2,085	2,398	2,186	2,489	2,199	1,969	1,738
81	1,523	1,849	2,127	1,939	2,208	1,950	1,746	1,542	1,750	2,125	2,444	2,228	2,537	2,240	2,006	1,771
82	1,550	1,882	2,164	1,973	2,246	1,984	1,777	1,571	1,781	2,162	2,486	2,267	2,581	2,280	2,041	1,805
83	1,574	1,911	2,198	2,004	2,282	2,015	1,805	1,598	1,809	2,196	2,525	2,302	2,621	2,315	2,073	1,836
84	1,598	1,940	2,231	2,034	2,316	2,045	1,832	1,626	1,836	2,229	2,563	2,337	2,661	2,350	2,105	1,869
85	1,619	1,966	2,261	2,061	2,347	2,073	1,856	1,654	1,860	2,258	2,597	2,368	2,696	2,381	2,132	1,900
86	1,639	1,989	2,288	2,086	2,375	2,098	1,880	1,681	1,883	2,285	2,628	2,397	2,728	2,410	2,160	1,932
87	1,657	2,012	2,314	2,112	2,402	2,123	1,905	1,710	1,904	2,312	2,659	2,426	2,760	2,440	2,189	1,964
88	1,676	2,034	2,339	2,136	2,428	2,148	1,930	1,737	1,925	2,337	2,688	2,455	2,790	2,468	2,217	1,996
89	1,689	2,052	2,365	2,162	2,455	2,174	1,955	1,766	1,941	2,358	2,717	2,484	2,821	2,498	2,246	2,029
90	1,702	2,071	2,392	2,189	2,483	2,201	1,981	1,796	1,956	2,379	2,748	2,515	2,852	2,528	2,276	2,063
91	1,713	2,089	2,419	2,215	2,510	2,227	2,007	1,826	1,968	2,401	2,779	2,545	2,884	2,559	2,306	2,098
92	1,723	2,108	2,446	2,243	2,539	2,255	2,035	1,857	1,980	2,422	2,810	2,577	2,917	2,591	2,338	2,133
93	1,733	2,127	2,474	2,270	2,568	2,283	2,062	1,888	1,991	2,444	2,842	2,608	2,950	2,623	2,369	2,169
94	1,743	2,147	2,503	2,299	2,598	2,312	2,091	1,921	2,003	2,467	2,876	2,642	2,985	2,656	2,403	2,207
95	1,753	2,167	2,533	2,329	2,629	2,341	2,121	1,954	2,014	2,489	2,910	2,676	3,020	2,690	2,436	2,246
96	1,763	2,187	2,563	2,359	2,660	2,372	2,151	1,989	2,026	2,512	2,945	2,710	3,056	2,725	2,471	2,285
97	1,773	2,206	2,594	2,389	2,692	2,402	2,181	2,024	2,037	2,535	2,980	2,745	3,093	2,760	2,506	2,325
98	1,783	2,227	2,625	2,421	2,724	2,434	2,213	2,060	2,049	2,559	3,016	2,781	3,130	2,796	2,543	2,367
99	1,793	2,248	2,658	2,453	2,758	2,466	2,246	2,097	2,060	2,583	3,054	2,819	3,169	2,833	2,581	2,410

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.

The Manhattan Life Insurance Company
Annual Standard Premium Rates
FOR USE IN INDIANA ZIP CODES ALL EXCEPT
462-464

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
65	1,081	1,313	1,510	1,377	1,568	1,385	1,240	1,095	1,243	1,508	1,735	1,582	1,801	1,591	1,425	1,257
66	1,081	1,313	1,510	1,377	1,568	1,385	1,240	1,095	1,243	1,508	1,735	1,582	1,801	1,591	1,425	1,257
67	1,081	1,313	1,510	1,377	1,568	1,385	1,240	1,095	1,243	1,508	1,735	1,582	1,801	1,591	1,425	1,257
68	1,125	1,365	1,571	1,432	1,630	1,440	1,289	1,139	1,293	1,569	1,804	1,646	1,873	1,654	1,482	1,308
69	1,169	1,420	1,634	1,488	1,695	1,497	1,341	1,184	1,344	1,631	1,877	1,711	1,947	1,720	1,540	1,360
70	1,217	1,477	1,700	1,549	1,763	1,558	1,395	1,231	1,398	1,697	1,953	1,780	2,026	1,790	1,603	1,415
71	1,266	1,537	1,767	1,612	1,834	1,620	1,451	1,280	1,454	1,766	2,031	1,851	2,108	1,861	1,667	1,472
72	1,315	1,596	1,836	1,674	1,905	1,683	1,507	1,331	1,510	1,834	2,110	1,923	2,190	1,934	1,731	1,529
73	1,366	1,659	1,907	1,739	1,980	1,749	1,566	1,383	1,570	1,905	2,191	1,999	2,275	2,010	1,800	1,588
74	1,411	1,714	1,971	1,797	2,046	1,807	1,618	1,428	1,621	1,969	2,265	2,065	2,351	2,076	1,859	1,641
75	1,455	1,767	2,033	1,854	2,110	1,863	1,669	1,473	1,672	2,031	2,335	2,129	2,424	2,141	1,917	1,692
76	1,498	1,819	2,092	1,907	2,171	1,918	1,717	1,516	1,722	2,090	2,404	2,191	2,495	2,203	1,973	1,741
77	1,537	1,866	2,146	1,957	2,228	1,968	1,762	1,555	1,766	2,144	2,465	2,248	2,560	2,261	2,024	1,786
78	1,575	1,912	2,199	2,005	2,283	2,016	1,805	1,594	1,810	2,197	2,527	2,303	2,622	2,317	2,075	1,832
79	1,612	1,956	2,250	2,050	2,335	2,063	1,847	1,630	1,851	2,247	2,584	2,356	2,683	2,369	2,122	1,873
80	1,645	1,997	2,296	2,093	2,383	2,105	1,885	1,664	1,890	2,294	2,638	2,405	2,738	2,419	2,166	1,912
81	1,675	2,034	2,340	2,133	2,429	2,145	1,921	1,696	1,925	2,338	2,688	2,451	2,791	2,464	2,207	1,948
82	1,705	2,070	2,380	2,170	2,471	2,182	1,955	1,728	1,959	2,378	2,735	2,494	2,839	2,508	2,245	1,986
83	1,731	2,102	2,418	2,204	2,510	2,217	1,986	1,758	1,990	2,416	2,778	2,532	2,883	2,547	2,280	2,020
84	1,758	2,134	2,454	2,237	2,548	2,250	2,015	1,789	2,020	2,452	2,819	2,571	2,927	2,585	2,316	2,056
85	1,781	2,163	2,487	2,267	2,582	2,280	2,042	1,819	2,046	2,484	2,857	2,605	2,966	2,619	2,345	2,090
86	1,803	2,188	2,517	2,295	2,613	2,308	2,068	1,849	2,071	2,514	2,891	2,637	3,001	2,651	2,376	2,125
87	1,823	2,213	2,545	2,323	2,642	2,335	2,096	1,881	2,094	2,543	2,925	2,669	3,036	2,684	2,408	2,160
88	1,844	2,237	2,573	2,350	2,671	2,363	2,123	1,911	2,118	2,571	2,957	2,701	3,069	2,715	2,439	2,196
89	1,858	2,257	2,602	2,378	2,701	2,391	2,151	1,943	2,135	2,594	2,989	2,732	3,103	2,748	2,471	2,232
90	1,872	2,278	2,631	2,408	2,731	2,421	2,179	1,976	2,152	2,617	3,023	2,767	3,137	2,781	2,504	2,269
91	1,884	2,298	2,661	2,437	2,761	2,450	2,208	2,009	2,165	2,641	3,057	2,800	3,172	2,815	2,537	2,308
92	1,895	2,319	2,691	2,467	2,793	2,481	2,239	2,043	2,178	2,664	3,091	2,835	3,209	2,850	2,572	2,346
93	1,906	2,340	2,721	2,497	2,825	2,511	2,268	2,077	2,190	2,688	3,126	2,869	3,245	2,885	2,606	2,386
94	1,917	2,362	2,753	2,529	2,858	2,543	2,300	2,113	2,203	2,714	3,164	2,906	3,284	2,922	2,643	2,428
95	1,928	2,384	2,786	2,562	2,892	2,575	2,333	2,149	2,215	2,738	3,201	2,944	3,322	2,959	2,680	2,471
96	1,939	2,406	2,819	2,595	2,926	2,609	2,366	2,188	2,229	2,763	3,240	2,981	3,362	2,998	2,718	2,514
97	1,950	2,427	2,853	2,628	2,961	2,642	2,399	2,226	2,241	2,789	3,278	3,020	3,402	3,036	2,757	2,558
98	1,961	2,450	2,888	2,663	2,996	2,677	2,434	2,266	2,254	2,815	3,318	3,059	3,443	3,076	2,797	2,604
99	1,972	2,473	2,924	2,698	3,034	2,713	2,471	2,307	2,266	2,841	3,359	3,101	3,486	3,116	2,839	2,651

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.

PREMIUM INFORMATION

The Manhattan Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, and state and zip code of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and The Manhattan Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at [10700 Northwest Freeway, Houston, Texas 77092]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither The Manhattan Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to serviced not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $[1156]	$0	[$1156] (Part A deductible)
61st thru 90th day	All but $[289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	$0	Up to [$144.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$1156] (Part A deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	$0	Up to [$144.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$1156] (Part A deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	[$140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	[$140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	[$140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$1156] (Part A deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$1156] (Part A deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	[$140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved amounts*	$0	[$140] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	[$140] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$1156] (Part A deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$578] (50% Part A deductible)	[$578] (50% Part A deductible)
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN M

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1156]	[$1156] (Part A deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed [$140] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare Approved Amounts*	$0	$0	[$140] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First [$140] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 [$140] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000.	$250 20% and amounts over the $50,000 lifetime maximum.